

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **53** Primary Registration District No. **3010** Registrar's No. **40047727** STATE FILE NUMBER

JAFILED 12 65

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Cape		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Scott	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cape Girardeau		Length of stay in 1b 5 hours	c. CITY OR TOWN Oran
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) -----
3. NAME OF DECEASED (Type or print) First Middle Last Theresa (NMN) Schaefer			4. DATE OF DEATH Month Day Year December 27, 1964
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1880
9. AGE (last birthday) 84		IF UNDER 1 YEAR Months 10 Days 22	IF UNDER 24 HR. Hours --- Min. ---
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) New Hamburg, Missouri
12. CITIZEN OF WHAT COUNTRY U. S. A.		13. NAME OF HUSBAND OR WIFE August John Schaefer	
13a. FATHER'S NAME Martin Hoffer		13b. MOTHER'S MAIDEN NAME Magdalena Huber	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Harold Schaefer - Oran, Missouri		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Hypertensive Myocarditis with Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 3-4 days 4-5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg.) 101st	20f. CITY, TOWN, OR LOCATION Oran, Mo.
21. I attended the deceased from 12-26-64 to 12-27-64 and last saw her alive on 12-26-64		Death occurred at 3:15 am on the date stated above, and to the best of my knowledge, from the causes stated.	
22. SIGNATURE (Degree or title) William J. Oehler M.D.		22b. ADDRESS Cape Girardeau Mo	22c. DATE SIGNED 1-4-65
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 29, 1964	23c. NAME OF CEMETERY OR CREMATORY Guardian Angel Cath. Cem.	23d. LOCATION (City, town, or county) (State) Oran, Missouri
24. FUNERAL DIRECTOR Earl J. Smith Funeral Home - Oran, Mo.		25. DATE RECD. BY LOCAL REG. 1-4-1965	26. REGISTRAR'S SIGNATURE Gene Kasten

USE BLACK INK OR TYPEWRITER RIBBON

JAN 14 1965

Statement by Licensed Embalmer
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Jack T. Burnett

Licensed Embalmer No. 4473

P. O. Address Chaffee, Mo.

43-55-51
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Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

C. E. ...

1-14-65

1-14-65